Appendix 5

HCFA 1500 Claim Form Instructions For Disposable Medical Supplies (DMS)

Use the following claim form completion instructions, ***not*** the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Do not include attachments unless instructed to do so. Complete the elements listed below as appropriate. No other elements are required.

Note: Medicaid providers should ***always*** verify recipient eligibility before rendering services.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "D" in the Medicaid check box for the service billed.

Element 1a - Insured's I.D. Number
Enter the recipient's 10-digit Medicaid identification number. Do not enter any other numbers or letters.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial. Write the name exactly as it appears on the Wisconsin Medicaid identification card.

Element 3 - Patient's Birth Date, Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) or in MM/DD/CCYY format (e.g., February 3, 1955, would be 02/03/1955). Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Injured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Third-party insurance (private insurance coverage) must be billed prior to billing Medicaid, unless the service does not require third-party billing as determined by Medicaid.

- When the recipient has dental (DEN) insurance only or has no private insurance, leave Element 9 blank.
- When the recipient has Wausau Health Protection Plan (HPP), Blue Cross (BLU), Wisconsin Physicians Service (WPS), CHAMPUS (CHA), or some other (OTH) private insurance, ***and*** the service requires third party billing according to the All-Provider Handbook, and *Medicaid Update*, dated December, 1998 (No. 98-38), then one of the following three other insurance (OI) explanation codes ***is required to*** be indicated in the ***first*** box of Element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID by health insurance. In Element 29 of this claim form, indicate the amount paid by health insurance to the provider or to the insured.
OI-D	DENIED by health insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do ***not*** use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES. The recipient has health insurance, but it was not billed for reasons including, but not limited to: • Recipient denied coverage or will not cooperate. • The provider knows the service in question is not covered by the carrier. • Health insurance failed to respond to initial and follow-up claims. • Benefits not assignable or cannot get assignment.

When the recipient is a member of an HMO, one of the following must be indicated, ***if applicable***:

Code	Description
OI-P	PAID by HMO. The amount paid is indicated on the claim.
OI-H	HMO does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO are not reimbursable by Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to: (not required)

Element 11 - Insured's Policy Group or FECA Number
Use the ***first*** box of this element for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Bill Medicare before billing Medicaid.

Element 11 should be left blank when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- The recipient's Medicaid file shows he or she does not have any Medicare coverage for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A. Services related to a diagnosis of chronic renal failure are the only exceptions.
- The ***non-physician*** provider's Medicaid file shows he or she is not Medicare certified. (This does not apply to physicians because Medicare will retroactively certify physicians for the date and the service provided if they held a valid license when the service was performed.)
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits (EOMB), but do not indicate on the claim form the amount Medicare paid.

If none of the above is true, a Medicare disclaimer code is necessary.
The following Medicare disclaimer codes can be used when appropriate:

Code Description

M-1 Medicare benefits exhausted. This code can be used when Medicare has denied the charges because the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use the M-1 disclaimer in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service provided is covered by Medicare Part A but is not payable due to benefits being exhausted.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service provided is covered by Medicare Part B, but is not payable due to benefits being exhausted.

M-5 Provider is not Medicare certified. This code can be used when providers are identified in Medicaid files as being Medicare certified, but are billing for dates of service before or after their Medicare certification effective dates.

Use M-5 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A but not for the date the service was provided.
- The recipient is eligible for Medicare Part A.
- The procedure provided is covered by Medicare Part A.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B but not for the date the service was provided.
- The recipient is eligible for Medicare Part B.
- The procedure provided is covered by Medicare Part B.

M-6 Recipient not Medicare eligible. This code can be used when Medicare denies payment for services related to ***chronic renal failure*** (diagnosis code 585) because the recipient is not eligible for Medicare. Medicare must be billed first, even when the recipient is identified in Medicaid files as not eligible for Medicare. Use the M-6 disclaimer code in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- Medicare denies the recipient eligibility.
- The service is related to chronic renal failure.

M-7 Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy, not billing errors. Use M-7 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is covered by Medicare Part A, but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, etc.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is covered by Medicare Part B, but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, etc.

M-8 Noncovered Medicare service. This code can be used when Medicare was not billed because the service, under certain circumstances related to the recipient's diagnosis, is not covered. Use M-8 in these two instances only:

For Medicare Part A (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part A.
- The recipient is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not under certain circumstances related to the recipient's diagnosis.

For Medicare Part B (all three criteria are required to be met):

- The provider is identified in Medicaid files as certified for Medicare Part B.
- The recipient is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not under certain circumstances related to the recipient's diagnosis.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Element 12 - Patient's or Authorized Person's Signature (not required)

Element 13 - Insured's or Authorized Person's Signature (not required)

Element 14 - Date of Current Illness, etc. (not required)

Element 15 - If Patient Has Had Similar Illness, Give First Date (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
Enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
Enter the referring/prescribing physician's six-character UPIN number. If the UPIN number is not available, enter the eight-digit Medicaid provider number or license number of the referring physician.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use (not required)

Element 20 - Outside Lab?
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab.

Element 21 - Diagnosis or Nature of Illness or Injury
Enter the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ("E") and manifestation ("M") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Medicaid denies claims without the appropriate ICD-9-CM diagnosis code. One source to order the complete ICD-9-CM code book is:

St. Anthony Publishing, Inc.
P. O. Box 96561
Washington, D.C. 20090
(800) 632-0123

Element 22 - Medicaid Resubmission Code (not required)

Element 23 - Prior Authorization Number
Enter the seven-digit prior authorization (PA) number from the approved PA request form. Services authorized under multiple PAs are required to be billed on a separate claim form with their respective PA numbers. Disposable medical supplies (DMS) requested over the monthly limitations must be prior authorized.

Element 24A - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY or MM/DD/CCYY format in the "From" field.
- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY or MM/DD/CCYY format in the "From" field, and subsequent dates of service in the "To" field by listing ***only*** the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service (TOS) code.

- All procedures have the same place of service (POS) code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge ***per detail line*** in Element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

Leave the element blank if Medicare is not billed because the recipient's Forward card indicated no Medicare coverage.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefit (EOMB) to the claim and do not indicate a Medicare disclaimer code in this blank. Do not enter Medicare paid amounts on the claim form. Refer to the All-Provider Handbook for more information about submitting claims for dual-entitlees.

Element 24B - Place of Service
Enter the appropriate Wisconsin Medicaid single-digit place of service (POS) code for each service. Refer to Appendix 3 of this section for a list of all allowable place of service codes and their descriptions.

Element 24C - Type of Service
Enter the appropriate Wisconsin Medicaid single-digit type of service (TOS) code for each service. Refer to Appendix 3 of this section for a list of all allowable type of service codes and their descriptions.

Element 24D - Procedures, Services, or Supplies
Enter the single most appropriate five-character HCFA Common Procedure Coding System (HCPCS) code, or local procedure code. Claims received without the appropriate HCPCS or local code are denied by Medicaid.

Only the HCPCS procedure codes in the most recent DMS Index (which is updated and sent out to providers periodically) are covered by Medicaid.

Modifiers
Enter the appropriate Medicaid modifier in the "Modifier" column of Element 24D. Medicaid-allowable modifiers can be found in the DMS Index.

Element 24E - Diagnosis Code
When multiple procedures related to different diagnoses are listed, enter the diagnosis code that corresponds with the procedure code in Element 24D. Enter the number (1, 2, 3, or 4) that corresponds to the appropriate diagnosis code listed in Element 21.

Element 24F - Charges
Enter the total charge for each line item.

Element 24G - Days or Units
Enter the total number of services billed for each line item.

Element 24H - EPSDT/Family Plan
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if ***both*** HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24I - EMG
Enter an "E" for ***each*** procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this Element blank.

Element 25 - Federal Tax I.D. Number (not required)

Element 26 - Patient's Account Number
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the Remittance and Status (R/S) Report.

Element 27 - Accept Assignment (not required)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in this element, "OI-P" must be indicated in Element 9.) Do ***not*** enter Medicare paid amounts in this field.

Element 30 - Balance Due
Enter the balance due as determined by subtracting the amount paid in Element 29 from the amount in Element 28.

Element 31 - Signature of Physician or Supplier
The provider or the authorized representative must sign in Element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY or MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 33 - Physician's, Supplier's Billing Name, Address, ZIP Code and Phone #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of billing provider. At the bottom of Element 33, enter the billing provider's eight-digit Medicaid provider number.